What kind of problem is “NHS Culture”?

As health organisations focus on what they will do to improve culture in the wake of Francis, there are three traps to avoid.

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In the tsunami of speculation and comment surrounding the publication of the Francis Report, pretty much everyone agrees on the need for fundamental change in “NHS culture”.

There can be no question that truly awful things have happened in British hospitals. But we need to be careful how we define the problem of “NHS culture” or we will end up with the wrong solutions.

As NHS organisations focus in on what they will do to improve “culture” in the wake of Francis, we see three traps awaiting the unwary.

The first of these is “mourning a lost utopia”

If we are committed to learning from past mistakes, we have to get the history right. The history of “NHS culture” is not a descent from compassion to depravity.

Researchers for the award-winning website www.healthtalkonline.org have interviewed thousands of UK patients and carers about their experiences of illness and care. It is true that many older interviewees extol the virtues of a lost NHS. Others, though, recall abominable experiences and compare the inhumanity of the old NHS with the compassionate, personalised and technically excellent care they received in recent times.

As one lady said of care in the 1950s, “if there’s such a word as un-empowering it was … you weren’t a human being”. Her recent hip replacement “was the absolute antithesis of that…the compassion, the humanity.”

The job the NHS is doing now, and the standards we expect of it, are radically different from those of the past. The good news is that the NHS has already changed its culture for the better, not just for the worse. What the NHS has done before, it can do again.

The second trap is believing that “culture directly determines what people do”

Thirty years ago, psychologists Darley and Batson published a seminal study of ‘Good Samaritan’ behaviour.

Students at the Princeton Theological Seminary were invited to participate in a study of religious vocation. Once they’d completed a questionnaire, experimenters sent them to deliver a presentation in a different building. A third were told they would be late, another third that they were on time, and a third that they were early. As participants made their way across campus, each encountered a man slumped on the ground in distress. He was an experimental confederate, and the point of the experiment was to see what the seminarians would do. The majority (63%) of those who feared they were late ignored the need for help and hurried on. The vast majority (90%) of those running early stopped to give assistance.

What we learn from such studies of helping behaviour is that neither “culture” nor “character” reliably predict who will give help when needed. What matters is the situation you are in. There was nothing wrong with the seminary’s “culture”, and there was no character defect in seminarians assigned to the ‘late’ group. The only difference between them and apparently altruistic peers was the task they’d been given.

What this research should make us think about is how healthcare practitioners define care work and signal what is important about the tasks they’re involved in. If the task is mainly “getting it done”, and patients who need help get in the way of “getting it done”, we are in deep trouble. If the task is demonstrating compassion, and patients who need help are opportunities to do just that, we can reasonably predict things will turn out for the better.

The third trap is “thinking of NHS Culture as monolithic”

The NHS is vast, complex, and frequently impervious to influence. “NHS culture” can feel like a huge chilly iceberg looming through the fog. The choice seems to be to run a hefty tow rope round and try to tug it in a new direction, or give up and sink. We think of these as the ‘hubris’ and ‘hopeless’ options. Both are scary, but also based on a false premise.

“NHS culture” is, we suggest, not a monolith but many local micro-cultures. All of these are recreated all of the time through the interactions of everyone involved. Local

micro-cultures express the multiplicity of goals, expectations, assumptions, and beliefs that are negotiated (mostly without realising it) in day-to-day business between managers, clinicians, patients and others.

Of course regulatory requirements, national standards, professional guidance and so on influence local micro-cultures. But this influence occurs when members of local micro-cultures make sense of external demands, and create ways to incorporate them into practice.

It is therefore little by little in day to day local interactions that big ideas are rendered into reliable good habits. We can see this process at work in the successes of the patient safety movement.

Not so long ago, clinicians regarded blood stream infections to be an inevitable complication of central venous catherisation. In Michigan, Pronovost understood that CVC insertion techniques were at the root of the problem and he developed better ones. Successfully eradicating infection required more than new techniques, though. It needed local clinical teams to negotiate new expectations about what was inevitable, and new beliefs about what was acceptable.

In her analysis of Pronovost's Michigan project Mary Dixon-Woods argues that sustainable improvement comes from renegotiating expectations and assumptions within clinical communities. The Michigan work shows that this can be done, and Dixon-Woods' analysis helps us to understand how.

These are difficult times for the NHS, but there are genuine grounds for optimism. Fantastic projects such as the Point of Care programme at the Kings Fund and the Health Foundation's work in co-producing health function through myriad local initiatives. These demonstrate that locally negotiated clinical, managerial and patient collaborations really do change "NHS culture" .

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